

**Sheila Kitzinger Programme at Green  
Templeton College, University of  
Oxford, Seminar on Midwifery  
Education**

**July 9-10th, 2018**

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## Acronyms

WHOCC – World Health Organization Collaborating Centres  
 ICM – International Confederation of Midwives  
 LSTM – Liverpool School of Tropical Medicine  
 WHO – World Health Organisation  
 RCOG – Royal College of Obstetricians and Gynaecologists  
 US AID – United States Agency for International Development  
 NMC- Nursing and Midwifery Council

## Acknowledgements

We are grateful for the support and involvement of:

The Sheila Kitzinger Programme at Green Templeton College, Oxford Brookes University, and the School of Nursing and Health Sciences, University of Dundee for funding support

The Steering Group: Ethel Burns, Billie Hunter, Fran McConville, Mary Renfrew

Additional support for writing the report: Adetoro Adegoke, Hannah McCauley

Administrative support from Ruth Loseby and Yoland Johnson

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## Overview of The Sheila Kitzinger Programme

The Sheila Kitzinger Programme (SKP) is funded by Sheila's husband Uwe Kitzinger, Emeritus Fellow of Green Templeton College, former Director of the Oxford Centre for Management Studies (1980-84) and the first President of Templeton College (1984-1991).

SKP honours the life and work of Sheila Kitzinger, a social anthropologist and a women's advocate. Sheila's practical and policy work ranged over a broad range of issues touching the human rights of prisoners, refugees and others marginalised by society on pretexts of race, religion or poverty. Above all she was a high-profile feminist campaigner for the empowerment of women to secure for them freedom and choice in pregnancy, childbirth and breastfeeding.

The SKP offers a unique platform to debate, discuss and reflect on this key issue of quality midwifery education with a wide range of stakeholders, including academics, health service leaders, development partners, national and global organisations and women's advocates. This is very much in line with Sheila Kitzinger's lifetime commitment to women's empowerment, support for midwifery, human rights, evidence-based practice and evidence-informed decision making.

**Sheila Kitzinger**  
**1929 – 2015**



## Executive summary

Quality midwifery education underpins the provision of quality midwifery care and is vital for the health and well-being of women, infants, and families. The quality of midwifery education varies between and within countries, however. Many midwifery education programmes in low income countries have been found to have inadequate content, inadequate learning and teaching materials, inadequate number and poorly trained educators, and poorly equipped clinical placement sites; and to lack basic content such as infection prevention and respectful maternity care <sup>1</sup>.

Critical barriers to achieving high quality sustainable midwifery education programmes have been linked to economic, political, social and cultural restrictions, which affect high, middle and low-income settings <sup>2,3</sup>. Economic and political restrictions affect the rights of midwives to practice the full scope of midwifery and for midwifery to be viewed as a discrete profession; whilst social and cultural restrictions restrict women's rights, education and employment. Over-medicalisation of maternal and newborn care is becoming more prevalent globally <sup>4</sup> and there is a need for all health systems to include strong midwifery to address this challenge.

These factors affect the provision of quality maternal, newborn and child care and have an influential negative impact on morbidity and mortality. Consequently, many countries do not have midwives, and instead use other cadres to provide some elements of the care needed by childbearing women and newborn infants. This not only adversely affects the quality of care but causes confusion about the contribution and role of midwives <sup>5</sup>. This is being recognised by governments, advocacy groups, and professional associations across the world, and active work is underway to develop and update standards and curricula for midwifery education globally.

To ensure consistent improvement there is a need to develop a global plan to strengthen midwifery education, in consultation with stakeholders including health service leaders, government, academics, partners, programmers, practitioners, and advocates. Such a plan would ensure that all countries and all stakeholders, acting in collaborative partnership, support the development, implementation and evaluation of effective midwifery education. This would be a key step towards achieving Universal Health Coverage (UHC), would help progress towards Sustainable Development Goal (SDG) 3, and would deliver on the Global Strategy for Women's, Children's, and Adolescents' Health (GSWCAH). Plans for coordinated action to strength midwifery are being put in place by the World Health Organization and the International Confederation of Midwives, supported by donors and advocacy groups. Midwifery has been selected as the special topic for Global Strategy for Women, Children's and Adolescent Health (GSWCAH) <sup>6</sup> report to the World Health Assembly 2019. This will inform the development of Midwifery Policy Guidance for governments and implementing partners. The SKP provides a unique opportunity to ensure people's voices feed into the development of this policy guidance.

The Sheila Kitzinger Programme (SKP) at Green Templeton College University of Oxford offered an opportunity to hold a seminar to inform the development of this plan. SKP

honours the life and work of Sheila Kitzinger, a social anthropologist who passionately and tirelessly campaigned for women's freedom and choice through pregnancy and beyond. The SKP platform offered a unique opportunity to debate, discuss and reflect on the issue of quality midwifery education with a wide range of key stakeholders, drawing on the inspiration of Sheila Kitzinger's lifetime commitment to women's empowerment, support for midwifery, human rights, evidence-based practice and evidence-informed decision making.

The seminar was held on the 9<sup>th</sup>-10<sup>th</sup> July 2018. There were 40 participants from academia and research, health service delivery, development agencies, women's networks and students. Collectively, they had a wealth of knowledge and experience of implementing and supporting midwifery education in diverse settings and countries.

The seminar aimed to identify evidence-informed strategies for midwifery education and an agenda for future research. The participants were given scenarios from fragile, low-, middle- and high-income countries and were asked to work together to identify the key enabling factors for strengthening midwifery education in each specific context. They were asked to produce key summaries and strategies for policy, practice and research regarding midwifery education, and develop a conceptual framework for each setting.

For high-income countries the main recommendation identified was the need to develop and implement a midwifery workforce plan so that every woman can access a midwife. This should be planned for every high-income-country irrespective of whether they already have an existing midwifery education system. Emphasis was placed on advocacy for midwives and midwifery and the need for midwifery to be politically active and adequately resourced. There is a need to create media campaigns and to challenge the way midwives are portrayed and represented by the media, as it is critical that the public value what midwives do and understand their role.

In middle-income countries the group recommended that midwives are educated to respond effectively and empathically to the changing cultural and contextual needs of women and families in their care. They felt that women, their families and the community should be involved in the process of education, and that the public discourse about midwifery needs to reflect the substantive scale and scope of the contribution that midwives can make. They recommended that midwifery education should be closely linked with practice settings, with clear linkages between universities and clinical placement partners. This would enable midwives to learn the academic, interpersonal and clinical skills to provide best care, to interpret best available evidence, and to challenge practices as and when required when negotiating personalised care. The group recommended that midwifery should be established as an autonomous and respected profession, hence the need to ensure inter-professional learning as well as the strengthening of midwifery organisations and associations. They recognised that currently there are variable strengths of midwives' organisations in middle-income countries, with regulatory frameworks either lacking or controlled by medical institutions.



In low-income countries it was recommended that having a multi-sectoral, costed implementation plan is critical to ensure linkages and support the funding and sustainability of facilities. The group discussed the need to develop and implement evidence-based content in midwifery education and to have the optimum theory and practice split. The group flagged the need for an adequate infrastructure for teaching facilities, and agreement on where the education is going to take place. They recommended university led education and that countries should aim for graduate midwifery education. The group highlighted that there should also be an accrediting body and system to ensure quality education which includes a quality improvement cycle, with senior midwifery leadership and accountability. The group also recommended that high quality full-scope midwifery education should be based on a human rights-based approach, be framed by political will, involve evidence, and be driven by what women want.

In fragile settings including situations of conflict, emergency, and lack of stable governance it was recommended that the communities are supported to identify what is needed and to develop local solutions. This should include strategies where individuals would be upskilled, educated and trained and then supported to return to the environment to work and develop their midwifery practice. It was emphasised that in many instances the route to practice will need to be accelerated as in this situation time and resources are limited. The education of midwives would have to be ongoing and the group identified a continual upskilling cycle to educate midwives to international standards. The issue of scope of practice was raised acknowledging that there is often a risk for midwives and other healthcare providers who may feel it necessary to work outside their scope of practice to meet local needs. The group explained that it is crucial that the midwife is integrated into the healthcare system and healthcare team but that this will require funding, increased accessibility and then life-long learning. The value of professional recognition and protecting the role of the midwife was also discussed. Changes need to happen at government level and policy level to drive these agendas. The group highlighted the additional challenges that fragile contexts create and that sustainability, although difficult, is critical; and thus, sustainability plans for midwifery education are required.

## Introduction

The third Sustainable Development Goal (SDG 3) aims to ensure healthy lives and promote well-being for all at all ages <sup>7</sup>. To achieve this goal, nine key targets must be achieved, including the ambitious targets of reducing the global maternal mortality ratio to less than 70 per 100,000 live births (Target 3.1) and ending preventable newborn and children's deaths (Target 3.2) (Box 1). Whilst each country faces specific challenges in its pursuit of achieving the SDGs, the most vulnerable countries, in particular, low-income countries and countries in situations of conflict and post-conflict deserve special attention <sup>7</sup>.

As facility births increase, so does the recognition that the routine over-medicalisation of normal pregnancy and birth causes harm and increases health costs, and can facilitate disrespect and abuse<sup>3</sup>. Although over medicalisation is typically seen to exist in high-income countries, health and social inequities mean that extremes coexist in low-, middle-, and high-income contexts. Ultimately, health-care providers and health systems need to ensure that all women receive high quality, evidence-based, equitable, and respectful care and having strong midwifery education everywhere is a key factor in achieving this goal <sup>1</sup>.

Quality midwifery care has been identified as a critical factor needed to improve the quality of care received by women and infants in all countries, and to improve health outcomes <sup>1, 8</sup>. The Lancet Series on Midwifery defines Midwifery as *"Skilled, knowledgeable and compassionate care for childbearing women, newborn, infants and families"* <sup>5</sup>. It emphasised that a wide range of health outcomes can be enhanced when care is provided by midwives who are educated, licensed, regulated, and integrated in the health system <sup>9, 10</sup>.

Quality midwifery education is vital for establishing a competent workforce that can improve maternal and newborn health. The quality of midwifery and of midwifery education varies widely between and within countries, however. Critical barriers to achieving high quality sustainable midwifery education programmes have been linked to economic, political, social, and cultural restrictions, and, to systemic gender inequality. Economic and political restrictions affect the rights of midwives to practice the full scope of midwifery practice; whilst social and cultural restrictions restrict women's rights, education and employment <sup>11, 12</sup>. Discrimination against women acts to reduce the status of midwifery in two ways; first, because midwives care for women, and second, because the great majority of midwives are themselves women. These barriers combined result in the provision of poor-quality education, poor quality maternal, newborn and childcare, and an increase in morbidity and mortality for women and children. There is an urgent need to address this challenge.

In this report, we present the findings of the global seminar that aimed to examine strategies to strengthen midwifery education globally, hosted by the Sheila Kitzinger Programme at Green Templeton College, University of Oxford.

## The seminar

The purpose of the seminar was to discuss and debate how to strengthen midwifery education to improve quality of care for all women, newborn infants and their families, and to enhance the achievement of UHC.

### Objectives

The objectives of the meeting were to:

- inform the implementation of quality education of midwives who reach international standards
- identify priorities for future research
- identify evidence-informed enabling factors, drawing on country case studies
- develop a conceptual model for the implementation of quality midwifery education, considering diverse contexts
- ensure the inclusion of SKP key principles in midwifery education (women's empowerment, human rights, evidence-based practice and evidence-informed decision-making)

## Day One

### Opening Session

#### Denise Lievesley

The meeting was formally opened by Denise Lievesley (Principal, Green Templeton College, University of Oxford) who gave participants a warm welcome. She described Green Templeton College as a graduate college, with around 600 graduate students from about 79 countries, with over 53% female students, and the average age of students being 29 years. Current subjects include health, medicine, social science, business and management. She emphasised the College's contribution to education, leadership and research in improving global health in general, and specifically in maternal, newborn and child health. Denise stated that Green Templeton College supports the empowerment of midwives. Drawing on her experience as a statistician who co-ordinated a Master of Research programme for nurses and midwives some years ago, she explained that is critical for nurses and midwives to engage with research, not only being the research assistant, but setting and answering the questions themselves.

#### Uwe Kitzinger

Uwe Kitzinger welcomed everyone to the seminar and highlighted what an important event it was, as Sheila would want us to pursue her life's work. He described his wife as a passionate and committed advocate for change. Uwe shared inspiring stories of Sheila's life and work as a natural childbirth activist who relentlessly campaigned for women to have the information, they need to make choices about childbirth and breastfeeding.

An anthropologist, and a believer in evidence-informed change, she wrote 'The experience of childbirth' <sup>12</sup> after giving birth to her fourth child. This was one of the first books to be

intended for both women and midwives. She was a great communicator, an actress, and a lay preacher in the Unitarian church. Evidence based, women focused, freedom and choice, family friendly were her key principles. Uwe expressed a hope that through the SKP, Sheila's motto of "*countering the counter revolution*" would continue.

### Mary Renfrew

Mary Renfrew welcomed the participants and emphasised how essential it is that key people and organisations work together in a forum such as the SKP to inform policy and strategy. She explained that there were two reasons for the seminar being held; firstly the unacceptable levels of mortality, low quality care, escalating interventions, and over-medicalised approaches that challenge low, middle, and high-income countries demand an informed and coordinated response; and secondly to acknowledge the contribution of Sheila Kitzinger and to build on her work and her consistent support for midwifery.

Mary described midwifery as "a vital solution to the challenges of providing high quality maternal and newborn care for all women and infants in all countries" However, midwifery remains a neglected and misunderstood profession in many countries. Midwifery and midwifery education remain largely invisible. Mary highlighted the link between good quality education and quality maternal care. She stated that midwifery education is key to unlocking many of the challenges in maternal and newborn health. She said that the unique group attending the seminar could support this work through the development of a strategy and conceptual framework to inform the implementation of quality education of midwives, and by identifying priorities for future research in this area.

Mary explained that among Sheila's guiding principles were human rights, evidence informed decision making, and women's empowerment. She described this opportunity as an innovative and exciting seminar that will help to move forward the thinking on the implementation of high quality, sustainable, midwifery education globally, and that would help to ensure that all women and newborn infants receive care from well-educated midwives.

While concluding her presentation, Mary emphasised the need to relentlessly focus on the needs of women and children; and to ensure that midwives are empowered as they are essential to women's care. Mary thanked SKP and Green Templeton College for the opportunity to develop this work; and Oxford Brookes University, University of Dundee, Cardiff University and the World Health Organization (WHO) and all participants for their support, and for responding to this call for action to help solve some of the serious challenges facing implementation of quality education for midwives.

### Fran McConville

Fran McConville described the global lack of data regarding what needs to be done to achieve quality midwifery care. She stated that there is still not a clearly defined framework or guidance for governments who are keen to improve midwifery education, or indeed establish midwifery within their countries. Poor midwifery education, with inadequately prepared faculty and low-quality clinical practice were identified as key determinants for

poor midwifery care. The WHO is funding four pieces of research to improve midwifery education and practice. Fran outlined the research areas and their preliminary findings:

- Policy Research

A systematic review identified a lack of clarity on what is meant by the terms “midwifery” and “education”, as these are used differently in different countries. Only weak evidence was identified on what the most effective and cost-effective ways to achieve midwifery skills education. The review highlights a shocking lack of investment in midwifery and midwifery education during the MDG period.

- Global Midwifery Educator Survey

Preliminary findings from the global midwifery education survey show that teaching skills are weak, especially regarding care of newborn infants and family planning. It also revealed that much current midwifery teaching is only theoretical, with limited clinical exposure. There are big gaps in midwifery skills education, weak education policy, and multiple education pathways with often minimal accreditation. Other reported findings from this survey showed that 40% of the midwifery teaching institutes lacked clean water and a fifth lacked adequate sanitation facilities.

- Key stakeholder interviews

A series of interviews were held with key stakeholders in global maternity care. Again, they revealed a lack of clarity on the use of the terms ‘midwifery’ and ‘education’. There is a global level absence of monitoring and evaluation of midwifery and of midwifery education. Limited information was identified about what are the best measurement and monitoring indicators and what is sustainable in midwifery education. Three key barriers were identified which affect the provision of quality of care by midwifery personnel; sociocultural, economic and professional barriers, all underpinned by gender inequality. All these militate against women’s rights, education, and employment, which in turn result in moral distress, burn out and poor quality of care.

Fran explained that midwifery has been selected as the special topic for Global Strategy for Women, Children’s and Adolescent Health (GSWCAH) <sup>6</sup> report to the World Health Assembly 2019. This will inform the development of Midwifery Policy Guidance for governments and implementing partners. The SKP provides a unique opportunity to ensure people’s voices feed into the development of this policy guidance. Once developed, the policy guidance will be available for online and other consultations.

## Networking event

A networking session was organised for the evening which included a short introduction of the Nursing Now Campaign by Lord Nigel Crisp. Lord Crisp gave a quick overview of this three-year global campaign, which is a collaboration between the International Council of

Nurses (ICN) and the WHO. He explained that the Nursing Now campaign is focused on achieving UHC. Half of the health workforce are nurses and midwives, therefore strengthening the nursing and midwifery workforce is crucial for the achievement of UHC. If something is not done to strengthen nursing and midwifery, health will not be strengthened, especially in LMICs.

So far, the Nursing Now campaign has been working to improve health globally by raising the profile and status of nursing in improving health. Examples so far include getting nurses onto Boards, getting nurses into leadership positions, improving research, and disseminating research outcomes in a better way and changing policy to strengthen nursing. Nigel stated that nurses are systematically undervalued and underutilised around the world. Nurses have reported that they are not able to work within their full scope particularly in countries like India, Portugal and Spain. He explained that nurses are at the heart of most healthcare teams, playing a crucial role in health promotion, disease prevention and treatment.

As the healthcare providers who are closest to the community, they play an important role in developing new models of community-based care and support local efforts to promote health and prevent disease. Nigel explained how essential the link and partnership with midwifery and nursing both is as it tend to overlap in many countries of the world. He expressed his interest in and commitment to supporting midwifery. He concluded by describing the next steps for the campaign including the development of a policy framework for nursing; ensuring the implementation of the recent report on Non-Communicable Diseases (NCDs); the first ever ICM-ICN joint statement; and ensuring the development of future generation of leadership for nursing.



Theresa Shaver, Sally Pairman, and Karyn Kaufman



Seminar participants at the evening session

## Day Two

Introductory session

Welcome: [Lesley Page](#)

Day 2 started with a welcome address by Lesley Page. She described Sheila as one of the most influential figures in natural childbirth and woman-centred care of modern times. A long-term friend of Sheila, Lesley shared that Sheila had an enormous impact on the management of birth not only in the UK but in many parts of the world. A woman full of energy, Sheila drew on her joy and experience of birth and became a powerful and

influential voice on women's involvement in childbirth. Through Sheila's voice, women's voices were heard. Sheila influenced maternity policy, particularly in the areas of woman-centred care and continuity of care; championed the introduction of birth plans; and led the Birth Crisis Network to support women who had experienced traumatic birth. Lesley concluded by stressing the need to know the politics that operate in health and that midwifery is critical to give choice to women and their families. Lesley has just prepared an entry for the Oxford Dictionary of Biographies about Sheila Kitzinger.

#### [Purpose and plan for the day: Mary Renfrew and Karyn Kaufman](#)

Mary Renfrew used current evidence to explain why midwifery matters. Although evidence shows that midwifery has a key contribution to make to improve maternal and newborn health, midwifery is inconsistently understood and implemented in many countries. She noted that the focus on this seminar would be on 'full-scope' midwifery – on the education of midwives who reach international standards and who provide all the elements included in the scope of midwifery in the QMNC framework in the Lancet Series on Midwifery<sup>5</sup>. There had been a longstanding under-investment in midwifery education, research and practice.

Mary highlighted that many countries do not have midwives and where they exist, midwives face barriers to practising full scope midwifery. Midwives report feeling disempowered and are often invisible in leadership, strategy, planning, research. To overcome these barriers Mary emphasised the need to get the approach to midwifery education right for the future of midwifery. Mary stated that to improve the quality of midwifery there is a need to improve knowledge of 'what works' in educational approaches.

Karyn presented the aim and objectives of the seminar. She emphasised the need to develop a conceptual framework or a road map that will consider core principles and enabling factors that have worked in a range of contexts. To achieve the day's objectives various methods will be used:

- Brief presentations from a diverse mix of presenters on examples of country programmes and particularly the factors that enhanced success
- Input from advocacy, researcher, policy, programme, practice, educator, student, regulators and donors at global, regional, national and local levels
- Group work to develop strategy, identify opportunities and gaps and develop a conceptual framework

#### [Towards quality care for all: the key contribution of midwifery education - an evidence-informed approach. Alison McFadden](#)

Alison McFadden presented the Quality Maternal and Newborn Care (QMNC) Framework from The Lancet Series on Midwifery<sup>5</sup>. She emphasised that quality midwifery education is critical to achieving quality maternal and newborn care for all and that a qualified midwife should be able to practice the full scope of midwifery.

The key principles guiding implementation of full scope of midwifery include:



- Skilled and compassionate care for all
- Preventive and supportive care throughout – not just birth
- Continuity, respect, understanding
- Knowledge and understanding of normality as well as complications
- Interdisciplinary working, embedded in the system – partnership working is critical

Alison described the evidence that shows that midwifery is associated with more efficient use of resources and improved outcomes when provided by midwives who were educated, trained, licensed, and regulated. Evidence shows that midwives are most effective when integrated into the health system in the context of effective teamwork, appropriate referral mechanisms and enough resources. Universal implementation of midwifery could reduce maternal and newborn mortality and stillbirth by over 80%<sup>5</sup>. Alison reiterated that the impact of full-scope midwifery is enormous<sup>5, 13</sup>, and includes:

- Reduction in maternal and newborn morbidity
- Reduction in rates of stillbirth
- Less preterm birth and low birthweight
- Reduced interventions in labour
- Improved psycho-social outcomes
- Increased birth spacing, contraceptive use
- Increased breastfeeding initiation and duration
- Shorter hospital stays and improved referral rates

Alison then reported the initial findings of a rapid evidence review and synthesis on midwifery education. This study aimed to examine the most efficient and effective ways for low and middle-income countries to conduct pre-service and in-service midwifery knowledge and skills education and training, both in the short and long term. The study mapped existing studies on midwifery education and training in low- and-middle-income-countries (LMICs) to the QMNC framework. Preliminary findings show:

- Relatively few studies
- Studies are weak in terms of establishing effectiveness of an intervention
- Limitations in description of education methods
- Studies did not address questions about how best to educate and train midwifery care providers to international standards or which skills are most needed by which cadres in which contexts
- Minimal/no evidence for longer-term impact on knowledge and skills
- No evidence regarding impact on outcomes for women, newborn, infants, and families
- No evidence regarding education for educators
- There is some higher quality evidence in high-income-countries

Key principles identified from individual studies on effective implementation of midwifery education programme are shown in Box 1.



### Box 1 Key principles identified from individual studies of midwifery skills education in LMICs

- Proper curriculum framework/theoretical basis, grounded in evidence
- Proper context for the delivery of midwifery care
  - legislation, regulation, education, professional associations
- Involving local staff and women in design of education programmes at all levels
- Mix of classroom, simulation and actual practice
- Understanding of common core midwifery knowledge and skills
  - thus, the need for using global competencies as a benchmark
- Consider impact - short and long term, on students, women/babies/families
- Agreed understanding of what midwifery is and who midwives are is needed

### Where we are - findings from work to date: Fran McConville

Fran McConville gave an overview of the midwifery education consultations to date. She described key outputs that were developed following consultation meetings in Dundee (2016), Geneva in (March 2018) and during the 2018 World Health Assembly. The core outputs from the meetings are as follows:

Three strategic priorities identified for midwifery education:

- Protect the title midwife
- Support development of midwifery leadership
- Alignment between stakeholders

Innovations and radical thinking regarding midwifery education:

- Redesign inter-professional midwifery education and training faculty
- Engage women

How will we do this?

- better research and evidence, governance and accountability mechanisms, address social, cultural, financial and gender related barriers, and do not only focus on the curriculum.

How is this relevant to conflict and humanitarian settings?

- emergency care specific to these settings taught within midwifery education
- midwifery leadership/voice in the emergency cluster
- research impact of midwifery-led care in emergencies

What will the impact and how will we measure it?

- measurement of WHO educator competencies and ICM competencies
- development of logic model for education with indicators for monitoring and evaluation

Fran re-emphasized the need to be able to present a clear framework or road map for action in May 2019 at the World Health Assembly. She described the WHO Nurturing Care Framework<sup>14</sup> and explained that it can be used as a guide to develop a framework for the development of midwifery education.

## Examples of developing midwifery education and core principles for effective implementation.

This section focused on a series of short presentations based on case studies from several countries. There were presentations from specific countries (Nigeria, New Zealand, Bangladesh, Vietnam, Chile, Canada); multi-country (Jhpiego, Eastern Europe) and presentations from the ICM, a women's representative, and midwifery students.

### Strengthening Midwifery Education in Northern Nigeria: Adetoro Adegoke

Adetoro gave an overview of the situation in Northern Nigeria especially as it relates to poor health outcomes and the inadequate number of female health workers, especially midwives in rural and hard-to-reach areas. Although about 75% of maternal deaths in Nigeria could be prevented with the help of skilled personnel, few women in northern Nigeria benefit from the support of a well-educated midwife or nurse. With the support of the UK Department for International Development, the Women for Health project (W4H) was established in 2012 to support six states in Northern Nigeria to produce their own front-line healthcare providers. Adegoke shared W4H's experience in working with communities to produce their own health workers, and in the process holding the health system accountable. The key success factors are outlined in Box 2.

#### Box 2: Key success factors – W4H Nigeria

- Adapt the midwifery education programme to respond to the capacity of the region
- Build on evidence
- Involve the communities...not only engagement but accountability
- Bring together the communities and government agencies responsible for the production, employment and distribution of health workers in the health system.
- Build the capacity of health training institution leadership for effective engagement of and advocacy with the government

### Development of Midwifery in New Zealand: Sally Pairman

Sally gave an overview of the development of midwifery in New Zealand. This encompasses both midwifery practice and midwifery education. The Midwives' Act was developed 1904, which fostered the establishment of midwife-led maternity 'homes'. More recently, the commencement of the direct entry education and strengthening of midwives' autonomy resulted in the current situation in New Zealand where all women receive women-centered, midwife-led, integrated, free maternity service using a midwifery model of partnership. The key success factors are outlined in Box 3.

#### Box 3: Key success factors - New Zealand

- Involve women: partnership in curriculum design, teaching, assessment
- Enable midwifery students to experience midwife-led continuity of care: begin with practice – partnership with women, partnership with midwives.
- Midwife teachers practice; midwife preceptors teach
- Make education accessible: blended models; hub and spoke; flexibility; sustainability; retention
- Integrate education within professional framework: Midwifery First Year of Practice; Midwifery Standards Review; Mentoring; Reflection

### Strengthening midwifery education in Bangladesh: Marie Klingberg-Alvin

Marie described Dalarna University's experience of implementing a capacity-building programme for midwifery educators in 38 Colleges in Bangladesh. A set of independent components were used; net-based master's programme in sexual and reproductive health and rights (SRHR), a Massive Open Online Course (MOOC), mentorship, simulation-based learning and the development and implementation of a standardized system for accreditation. Monitoring, mentoring and supportive supervision mechanisms are included in these components ensuring quality and building sustainability of the midwifery education in Bangladesh. The key success factors are outlined in Box 4.

#### Box 4: Key success factors - Bangladesh

- Local political and policy commitment: strategic actions/directions since 2007. The Midwifery Strategic Directions 2014 and implementation of the Midwifery Services Framework (MSF) 2016.
- Collaborative network to harmonize activities in order to bridge higher education and research with policy, regulation and practice
- Local engagement through training of trainers. Midwifery educators/master students were used as *Agents for change* - to review/update clinical guidelines, curricula development and building accreditation system.
- Flexibility, created by using innovative pedagogical development using information computer technology

### Reflecting on an educational project in Vietnam 2002-2009: Ethel Burns

Ethel described her experience of supporting an educational project in Vietnam between 2002- 2009. She explained that midwives were initially educated in secondary medical schools with doctors as midwifery educators. The teaching style was mainly didactic and about 30% of the curriculum was allocated to national defence activities. Key success factors are outlined in Box 5.

#### Box 5: Key success factors - Vietnam

- Optimise the potential of resources to hand – retain cultural awareness and sensitivity
- Actively involve students from the onset
- Lobby and negotiate to shrink stakeholder barriers and champion equity

### Midwifery Education in Canada: Karyn Kaufman

Karyn gave an overview of the emergence of midwifery education in Canada, where midwifery was not legal until the 1990s. She explained that there was a broad context of policy reform of health professions. The key driver for midwifery and midwifery education in Canada was public support for changes in care. These included women who raised their voices and were strategic advocates; the use of key champions within government in both health and education. These led to the development and growth of an autonomous and well-regulated midwifery practice and education.

### Midwifery Education: A Jhpiego perspective on successful implementation: Peter Johnson

Peter described Jhpiego's experience of supporting professional health workers education in over 40 countries. For more than 40 years, Jhpiego has enhanced knowledge of health workers and developed the competency-based training needed for their optimal job performance. Peter explained that Jhpiego's approach to pre-service education programmes is focused on sustaining the competency of health workers as life-long learners.

Pre-service education has the goal of advancing health equity not only between but within countries ensuring the interests of the health workers themselves, the population they serve and the government. He explained the conceptual model that underpins Jhpiego's approach to pre-service education, which shows a relationship between inputs and processes that lead to the desired outcome. He further explained that although the intended outcome of any competency-based education is quality health service delivery, current evidence however shows that this linkage is not well developed. He described various elements that have contributed to the successes of Jhpiego's experience around the world. They include effective clinical practice, coordination, building local capacity and applying available evidence. The key success factors are outlined in Box 7.

#### Box 7: Key success factors - Jhpiego

- Take a comprehensive approach
- Concurrent investment in regulatory strengthening
- Begin with a comprehensive rapid assessment
- Have a capacity building focus
- Focus on skills/clinical

### Strengthening competency-based education in Latin America: Lorena Binfá

Lorena described the experience of the University of Chile to strengthen competency-based midwifery education in Latin America through Training of Trainers in CBE, evaluation and clinical simulation (Argentina, Ecuador, El Salvador, Brazil, México, Paraguay, Peru, and Uruguay). At the inception, no country was using competency-based education. The university also supported the development of midwifery programs in Bolivia and later curriculum mapping and follow-up. . They worked very closely with local communities and key stakeholders. This helped not only to strengthen the development of the competency-based curriculum but also to support its implementation. The success factors for this project are in Box 8.

#### Box 8: Key success factors - Bolivia

- Engage local people - stakeholders, key informants
- Strengthen competencies (Training of Trainers, scaling up)
- Ensure agreement - sign a memorandum of understanding
- Follow up and feedback

#### Application of the MATE Tool in Eastern Europe: Grace Thomas

Grace described Cardiff University's experience of developing and piloting the Midwifery Assessment Tool for Education (MATE) in Eastern Europe. This is one of Cardiff University's activities as a designated WHO Collaborating Centre for Midwifery Education. MATE is an evidence-based guide which informs discussion and provides links to useful resources. MATE asks midwives / leaders / women to self-assess or re-evaluate where they are now, where they envision future midwifery education and what they need to achieve this. The pilot involved a wide range of participants in Czech Republic, Lithuania and Bulgaria, including midwifery lecturers, regulators, association, practising midwives and midwifery students. A key success factor is ownership in country and MATE could be used globally to support development of midwifery education.

#### Dr Sally Pairman, Chief Executive, ICM: The International Confederation of Midwives

Sally described the core activities of the ICM. These include:

Developing and updating essential competencies for midwifery practice

- Midwifery Education and Accreditation Programme
- The ICM Midwifery Education Development Pathway (MedPath)
- ICM Global Midwifery Competency Assessment Process for educators, regulators and practitioners
- Midwifery Services Framework
- ICM Midwifery Consultancy services. This will provide technical assistance on training, accrediting and certifying Midwife consultants in ICM resources and programmes to build capacity and improve quality.

The key success factors discussed by Sally were: country commitment; global standards; government/donor investment; supportive partners; and a consistent approach.

#### Students' views on midwifery education: Tori Fleet and Harriet Cole

Tori and Harriet described their experiences as student midwives and how to improve the support provided and received by students for quality midwifery education. They described the implications of high workload on mentors and how that affects how and what students learn. They described how the support from peers led to pre-placement meetings with mentors to agree learning objectives.

#### Women's perspectives on midwifery education in the UK: Leah Morantz

Leah described why it is crucial that women remain at the centre when planning and providing women's health care. The aim of midwifery education should be to improve women's health and experience of childbirth. She stressed the importance of involving women during educational development and review. Women are the experts on their bodies, and given the right information can make informed decisions and judgements about themselves and their babies. She stated that clearly it is not enough to inform women, but it is important to empower women. Midwives should support the empowerment of women and Leah highlighted that women's health is a political issue.

Summary of key success factors from short presentations: Adetoro Adegoke and Hannah McCauley

Further to the country case studies and short presentations, key factors enabling the implementation of effective midwifery education programme were identified by Adetoro and Hannah. The ten key factors identified were presented and discussed in plenary and formed the foundation for the group work and discussions. These were:

1. Involve women, students and communities in all aspects of midwifery education – partnership in curriculum development and evaluation
2. Make education accessible – blended models, flexibility
3. Functioning practice sites with strong mentorship and support systems are essential
4. Country commitment and vision is essential
5. Global standards are the goal – then need to adapt midwifery programmes to be setting specific
6. Ensure collaboration and multi-sectoral linkages: bringing together the communities and government agencies
7. Advocacy, political and policy commitment is essential
8. Use available evidence: do not reinvent the wheel – partners need to collaborate to ensure harmonisation and alignment and avoid duplication
9. Monitoring and evaluation of education is essential to ensure adaptive programming
10. Build on evidence to develop rigorous educational programmes to include the content as well as how to implement sustainable high-quality change

### Group work activity

The aim of the group work was to identify evidence-informed strategies for midwifery education and an agenda for future research. Using the key success factors and enablers described from the country case studies, each of the four groups was to use the scenario provided, to identify the key enabling factors for the specific context and to produce key summaries and strategies for policy, practice and research, and if possible developing a conceptual framework or a road map.

Participants were divided into four interdisciplinary groups to work on four scenarios (see Appendix 1).

- Group 1: Fragile country
- Group 2: High-income-country
- Group 3: Middle-income-country
- Group 4: Low-income-country

The key activities for the group work were:

- Identify the enabling factors for implementation of quality education
- Develop a framework/roadmap for sustainable high-quality midwifery education
- Identify the key research questions to inform the enabling factors

## Feedback from groups and plenary discussion

### Group 1: Fragile country

#### Enabling factors to support the development of midwifery education

The group described what a fragile country was; these included emergency situations, conflict and humanitarian situations, and they described how this influenced their discussions and group outputs. The enablers identified by the group were described in two parts to ensure not only preparedness and response but to foster stability and build resilience. Table 1 shows the enabling factors identified for the implementation of quality midwifery education in a fragile country.

Table 1: Enabling factors for implementation of quality midwifery education in a fragile country

Preparedness
1. Route to practice: <ul style="list-style-type: none"><li>• Accelerated</li><li>• Continuing</li><li>• Stepped (upskilling to full scope)</li><li>• Context specific</li></ul>
2. Community focused: <ul style="list-style-type: none"><li>• Linkages</li><li>• Peer support</li></ul>
3. Integrate midwife into the system: <ul style="list-style-type: none"><li>• Funding</li><li>• Increase accessibility</li></ul>
4. Professional recognition: <ul style="list-style-type: none"><li>• Protecting title</li><li>• Part of system-motivation</li><li>• Recognition by local leaders</li></ul>
5. Professional support: <ul style="list-style-type: none"><li>• Part of multidisciplinary team</li><li>• Midwifery community/association</li><li>• Lifelong learning</li></ul>
Response
6. Policy environment: <ul style="list-style-type: none"><li>• Scope</li><li>• Trained/education</li></ul>
7. International actors: <ul style="list-style-type: none"><li>• On board/recognise the role of midwives</li><li>• Capacity building</li></ul>
8. Sustainability plan: <ul style="list-style-type: none"><li>• Pragmatic</li><li>• Context specific</li></ul>
9. Coordination: <ul style="list-style-type: none"><li>• Avoid duplication</li></ul>

### Conceptual framework to develop sustainable midwifery education in fragile setting

The group explained that they spent some time discussing how the community should drive the changes needed. They described the value of communities and how essential it is that communities identify what they need and then develop local solutions to that. This should include strategies where individuals would be upskilled, educated and trained, and then return to that environment to work and develop their midwifery practice. It was emphasised that in many instances the route to practice will need to be accelerated as in this situation there is often not enough time. The education of midwives would have to be ongoing and the group identified a continual upskilling cycle to eventually train full scope midwives. The group raised the issue of scope of practice and discussed that there is often a risk for midwives and other healthcare providers as there are constant tensions around them moving outside their scope of practice due to the local needs.

The importance of linkages was also discussed as a critical component of this framework, both the linkages that the individual would need to foster and the link between different cadres of healthcare providers. The group highlighted that peer support was essential in this agenda. The group explained that it is crucial that the midwife is integrated into the healthcare system and healthcare team but that this will require funding, increased accessibility and then life-long learning.

The value of professional recognition and protecting the role of the midwife was also discussed, and that changes need to happen at government level and policy level to drive these agendas. The group highlighted additional challenges that fragility creates, especially in regard to some of the international agencies and NGOs where healthcare providers may 'swoop in' to undertake a paired piece of work and then 'swoop out' again without building local capacity. Sustainability although difficult is critical, and sustainability plans for midwifery education are needed. Also, as there will be different players, there needs to be coordination to avoid duplication of activities.

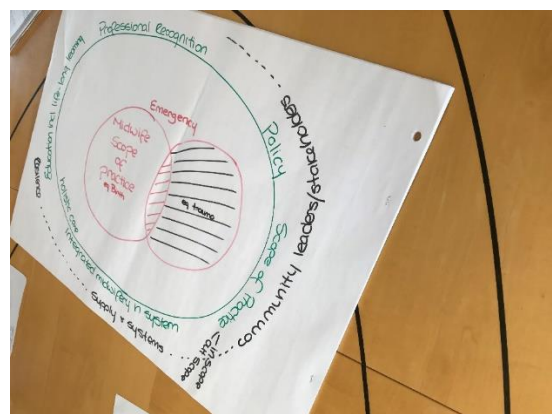
### Key research questions

- What are the views of women and families about care needs in this acute situation (expectations, perceptions, experiences, rights)?
- What are the benefits and risks of midwives working in a wider public health role? How wide should it be?
- What lessons can be learnt from countries that have successfully task shifted?
- How do we ensure midwives have skills to be strong, flexible, and responsive to the context they are working in?
- What is the optimal skill mix/role and responsibilities in this acute situation?



- How can we scale up innovations e.g. digital hubs?

### Group 1 - Fragile setting: Group work and conceptual framework



### Group 2: High-income-country

#### Enabling factors to support the development of midwifery education

Table 2 shows the enabling factors identified by the group regarding how to strengthen sustainable midwifery education in high-income-countries. The aim of identifying the enablers is to ensure quality midwifery education is responsive to future developments. The group discussed that the enabling factors outlined will ensure that midwives are supported and protected, and that midwifery is promoted. This will result in a midwifery profession that is valued, humanised, compassionate and evidence based, adequately resourced and responsive.

Table 2: Enabling factors for strengthening sustainable midwifery education in High Income Country

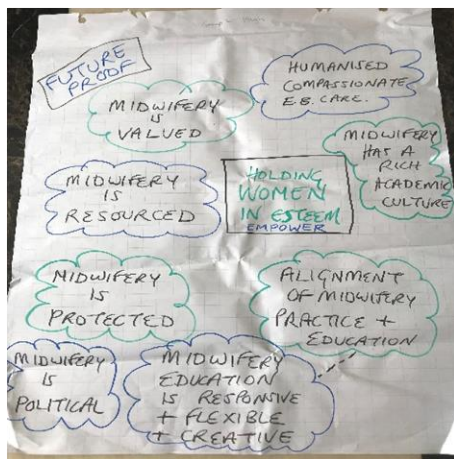
Enabling factors	
1. Recognise differences in countries:	<ul style="list-style-type: none"> <li>• Understand context</li> <li>• Political understanding of women's health/policies/reproductive health</li> </ul>
2. General understanding of midwifery (role, value and status):	<ul style="list-style-type: none"> <li>• Public</li> <li>• Health system providers</li> <li>• Culture and reality</li> </ul>
3. Aligning practice and education:	<ul style="list-style-type: none"> <li>• Shared philosophy</li> <li>• Shared synergy</li> </ul>
4. Access for students:	<ul style="list-style-type: none"> <li>• Resources and finance</li> <li>• Affordability</li> </ul>
5. Women and student voices:	<ul style="list-style-type: none"> <li>• Partnership</li> </ul>

<ul style="list-style-type: none"> <li>• Co-creation</li> <li>• Political</li> </ul>
6. Use of emerging technologies: <ul style="list-style-type: none"> <li>• Creative</li> <li>• Careful</li> </ul>
7. Rich academic culture: <ul style="list-style-type: none"> <li>• Research</li> <li>• Career development</li> <li>• Leadership</li> </ul>
8. Educational faculty: <ul style="list-style-type: none"> <li>• Midwifery educators also practice midwifery</li> <li>• Clinicians also empowered to teach</li> </ul>
9. Inter professional education: <ul style="list-style-type: none"> <li>• Respect, compassion and mutual understanding</li> <li>• Value of caring role</li> <li>• Challenge power balance</li> <li>• Managing expectations</li> </ul>
10. Workforce modelling: <ul style="list-style-type: none"> <li>• Career framework</li> <li>• Clinical Practice Development culture at universities and in clinical practice</li> </ul>
11. Exposure to a range of midwifery practice: <ul style="list-style-type: none"> <li>• Elective exchange</li> <li>• Home birth</li> <li>• Midwifery-led care</li> <li>• Case loading</li> <li>• Hospital setting</li> </ul>
12. Professional Associations providing: <ul style="list-style-type: none"> <li>• Career framework</li> <li>• Educational advice</li> <li>• Coordination</li> </ul>
13. Regulatory framework
14. Length of programme: <ul style="list-style-type: none"> <li>• Flexibility to address individuals</li> </ul>

Conceptual framework to develop a sustainable midwifery education in a high-income-country.

The group presented a conceptual framework to develop and strengthen sustainable midwifery education in a high-income country. The framework has at the centre the woman, the baby and the family, and they were surrounded with humanistic, compassionate and evidence-based care. At the second layer, the factors that need to be in place for full scope midwifery care and education are outlined, namely the academic culture. The group explained that they felt that the education of midwives should be in university settings. The group explained the critical linkage between practice and education. Both practice and education should be linked, co-dependant and feed into each other. This education should also be supportive, flexible and integrated. This is surrounded by the wider factors of protection and regulation; it would be a political culture and midwifery would be

#### Group 2 - High Income Country: Group work and conceptual framework



valued.

Other key strategic actions developed as part of the framework include: the need to develop and implement a midwifery workforce plan so that every woman can access a midwife - this was planned for every high-income-country irrespective of whether they had already an existing midwifery education system or not.

Although midwifery is valued in most high-income-countries there were a lot of discussions on how this can be built into political action to ensure a sustainable educational programme. Emphasis was placed on advocacy for midwives and midwifery and the need for midwifery to be political and adequately resourced. There was discussion on how to create media campaigns and how to challenge the way midwives are portrayed and represented by the media, as it is critical that the society values what midwives do and understands their role.

A key value was aligning academic institutes and practice institutions where possible, to create a culture of ongoing development. Career pathways should be visible right from undergraduate to postgraduate level to make midwifery an attractive profession to enter.

There was also discussion surrounding the fact that education models can change over time, and flexibility with students is essential, especially those who might have caring responsibilities.

#### Key research questions

- What is the practice impact of education interventions?
- What is the impact of midwifery “mentors” on the graduate midwife?
- Is there a different way to deliver midwifery education?
- What are the key factors for aligning midwifery education and practice?

## Group 3: Middle-income-country

#### Enabling factors to support the development of midwifery education

Table 3 shows the enabling factors identified by the group on how to strengthen sustainable midwifery education in middle-income-country.

Table 3: Enabling factors for strengthening sustainable midwifery education in Middle Income Country

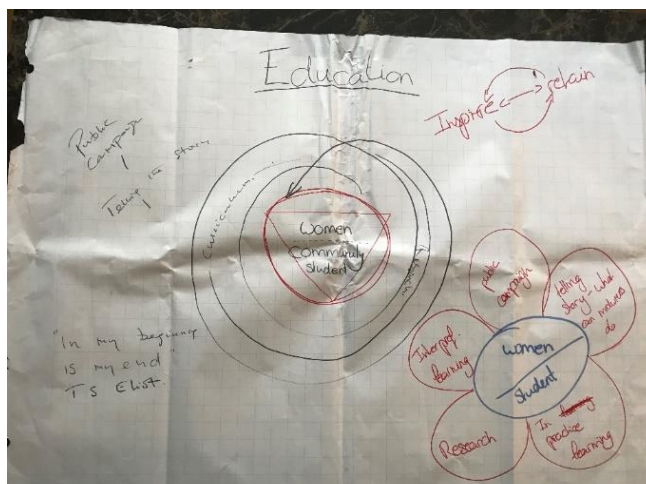
Enabling factors
1. Inter-professional learning
2. Research
3. In practice learning
4. Public campaign
5. Telling stories: <ul style="list-style-type: none"> <li>• Who are midwives</li> <li>• What can they do</li> </ul>

#### Conceptual framework to develop a sustainable midwifery education in middle-income-countries

The group elaborated on the implications of strengthening midwifery in middle-income-countries and how it was important that they define it as they start the group work. They explained that middle-income countries include India, Brazil, China and that it can also vary to include countries like Nigeria, which is a broad spectrum of different types of setting. The group recognised that these countries all have very large populations, which has a significant impact on the achievement of the SDGs. There were also significant discussions within the group on who should be at the centre of the framework. The group discussed if it should include women and the community, women and their families, or only families or only students. The group agreed this would depend on how each is defined with the need for a clear definition before a final framework is presented at the WHA in 2019.

The group also explained that since midwifery is a profession that evolves a lot, that there is the need for a curriculum that is also quite flexible and that evolves round the culture itself hence the need for the spiral, where the curriculum and research are spiralling around and

### Group 3 - Middle Income Country: Feedback and conceptual framework



feed into the community and the training of the midwives.

An important discussion was that in some middle-income-countries although midwives were educated, they were not being allowed to practice to their full scope so there was the need to make sure that there is a link between inspiring people to become midwives and continuing to inspire midwives after training. Resources should be committed by the government to ensure that midwives are retained within the countries to continue working.

Putting women or students at the centre of the framework ensures that countries would implement midwifery education that is accepted by society. There is a need for advocacy and campaigns to women's groups and to community leaders such as Imams, priests or heads of villages. The importance of telling the story of midwifery was also shared. There is the need to show what midwives can do, so people will understand the profession and want to support midwives and be cared for by midwives. There were discussions around the type of education and the need for such to be practice driven with clear linkages between universities and practice sites. Research was identified as a critical part of midwifery education. Midwifery should be an autonomous and respected profession, hence the need to ensure inter-professional learning as well as the strengthening of midwifery organisations and associations. The group recognised that currently there are variable strengths of midwives' organisations in middle-income countries, with regulatory frameworks either lacking or integrated into or regulated by medical institutions.

The group discussed what they felt was important and innovative within the context of midwifery education and felt that is essential that midwifery and midwifery education are part of community development, with the potential to improve women's status. They recommended having midwives and midwifery students in the communities working with

women to develop public health initiatives to improve women's status. The group drew on the key learning from the country case study presented from Nigeria.

#### Key research questions

- How can midwives be educated and retained in their countries?
- How can we promote midwifery so that people believe in midwifery and can invest in midwifery education programmes?
- How do we monitor how many midwives stay working? Where? And how long?
- What are the best ways to tell the “midwives’ story” and how do we inspire midwives to tell their stories to capture heads and hearts?
- Use existing data from country and evidence from other countries to show risks (health) and to demonstrate costs of needless interventions (e.g. increase C/S rates etc.)
- What are the barriers and enablers to respectful maternity care?
- What is the impact of non-respectful maternity care on women and their families?
- What is the impact of non-evidence-based practices (e.g. lying supine, being left alone, no food or drinks) on women in labour?

#### Group 4: Low Income Country

##### Enabling factors to support the development of midwifery education

Table 4 shows the enabling factors identified by the group on how to develop sustainable midwifery education in low-income countries.

Table 4: Enabling factors for implementation of quality midwifery education in low-income-countries

Enabling factors	
1. Understanding need and urgency	<ul style="list-style-type: none"> <li>• Number of midwives needed</li> <li>• Distribution needed</li> <li>• Time to prepare</li> </ul>
2. Consensus/agreement on what a midwife is:	<ul style="list-style-type: none"> <li>• Agreement developed through multi-stakeholder dialogue including women</li> <li>• Principles, values, philosophy</li> <li>• Use of QMNC framework</li> <li>• Human rights</li> </ul>
3. Government support	<ul style="list-style-type: none"> <li>• National and subnational</li> <li>• Linked into global and national priorities</li> <li>• Steering group developed</li> </ul>
4. Costed implementation plan for midwifery education based on:	<ul style="list-style-type: none"> <li>• Number of midwives needed</li> <li>• Number of training institutions and training faculty</li> <li>• Ideally, free education</li> </ul>
5. Skilled faculty:	<ul style="list-style-type: none"> <li>• Theory and practice as part of role</li> <li>• Education competencies defined</li> </ul>



<ul style="list-style-type: none"> <li>• Resources available to provide training</li> <li>• Best practices based on evidence</li> </ul>
6. Content <ul style="list-style-type: none"> <li>• Educational best practices-pedagogy</li> <li>• Best practices for full scope midwifery</li> </ul>
7. Infrastructure for educational facilities <ul style="list-style-type: none"> <li>• Multidisciplinary learning</li> <li>• Virtual facilities, distance learning, web-based learning</li> <li>• Assess best setting and consider pros and cons of each pathway:             <ul style="list-style-type: none"> <li>• University versus non-university settings</li> <li>• Nursing versus direct entry</li> <li>• Geographic distribution</li> </ul> </li> </ul>
8. Adequate practical experience and sites <ul style="list-style-type: none"> <li>• Theory integrated into practice</li> <li>• Supervision/mentorship</li> </ul>
9. Leadership and accountability <ul style="list-style-type: none"> <li>• Accreditation body for education programmes</li> <li>• Accountability also applying to private sector</li> </ul>
10. Culture of continuous quality improvement based on what women need and want

#### Conceptual framework to develop a sustainable midwifery education in low-income-country

The group discussed the strategic actions needed to develop sustainable midwifery education in low-income countries using a step by step road map. Describing the roadmap that was developed, the group emphasised the importance of identifying where on the map individual countries were, based on what their needs are. The group emphasised the need to understand the nature of the problem that needs to be solved, understanding what the need is and, particularly in relation to the urgency and the number of midwives needed, the time it will take to prepare them.

The group discussed the importance of the definition of midwifery to multi-stakeholder consensus, and ensuring that this is widely disseminated. The importance of involving government and political support at the commencement of any education programme development was highlighted, and that this support should continue in the long term. The group suggested that having a senior champion or an agent of change who will safeguard and pioneer the idea whilst also steering the group would be important to ensure effective, sustainable, and visible change. The group also stressed that at some point as countries go through the roadmap, they may face some barriers and challenges that can make them want to stop but that this should be taken as opportunities to reflect and evaluate.

Having a multi-sectoral costed implementation plan is critical to ensure linkages and to support the funding and sustenance of facilities. The group highlighted that having adequate skilled midwifery teaching faculty is needed as well as a well-functioning educational facilities.

The group discussed the need to develop and implement evidence-based content, what should be in the midwifery education programme, again using available resources including the Royal College of Midwives UK, ICM and WHO midwifery education packages. They discussed the importance of ensuring adequate infrastructure for teaching facility, and the need for agreement on where the education is going to take place. The group stressed the country should aim for the best quality education, and ideally this should be a university led education and that countries should aim for graduate midwifery training. This education could be achieved by using different education methodologies including distance learning, sharing with other universities across the world, so that it doesn't necessarily have to be solely based in the country. There are some good examples of setting up distance learning education that low-income-countries could use.

The need to identify adequate clinical placement sites was discussed by the group, and the

#### Group 4 - Low Income Country: Group work and Feedback



importance of not only having the theory input but also the practice so students can learn the skills required and have adequate time within the curriculum allocated for this. The group highlighted that there should also be an accrediting body and system to ensure quality education which feeds into having a quality improvement cycle, with robust midwifery leadership and accountability. There was also discussion of the importance of having a culture of quality improvement based on what women need and want, and ensuring that this is embedded in a human rights perspective. So essentially, all the important things the country wants to achieve are at the top of the road map - high quality full scope midwifery education, human rights-based approach; framed by political will, research, effectiveness and accountability; and importantly what women need and want.

#### Key research questions

- What is skilled midwifery faculty (supervised clinical practice – educating the educators – competencies educator ICM – updating etc.)



- What is the best way to support and develop midwifery faculty (via training) to ensure it is sustainable and effective? Mentorship – blended learning etc.
- What is the best way to upskill midwifery practitioners to full scope midwifery?
- Scoping/mapping exercise – setting definitive targets – number of midwives – how long will it take to train up midwives?
- Cost implementation – what would it cost to educate midwives?
- What is the cost of an adequate faculty and ensuring that there are enough practice placements?
- Is free education achievable or how can it be made affordable?
- What is the best content balance of midwifery education (practice vs theory)?
- What support supervision/ mentorship is needed to support students to become midwives trained to international standards?
- What is the right model for mentorship?
- Problem based learning and competency-based education – is simulation an effective way to teach – is it the best way to teach students?
- Where and how do students learn best? Mixed methods? Multi-disciplinary teaching?
- What do women want midwifery education to look like?
- What do students want midwifery education to look like?
- What do midwives want midwifery education to look like?
- What is the best way to train other cadres to full scope midwifery?
- How long should midwifery training be? International consensus.

### Plenary discussion

The day ended with a plenary discussion that was focused on midwifery education in a fragile country or during emergencies. It was highlighted that midwives have a key role in such situations, as they may already be in place and may know the local populations. Although donors, healthcare providers, and agencies arrive in countries to provide aid during humanitarian disasters, they may not know the area, and may never have been trained in providing care in this context. The group felt it is important that indigenous midwives are better placed to meet these needs, and noted that with better education they can be prepared in advance before the crisis. Existing midwifery education does not prepare midwives around key areas of needs, however, such as dealing with emergencies, post-traumatic stress (PTS), or abuse.

It was agreed that midwives' role in the provision in family planning is critical, especially in emergencies and in fragile states, and educational needs in this area should be reviewed and updated. There were also concerns that while midwives may be dealing with women who have experienced trauma, if they are part of that community, they themselves may also have experienced trauma. This has implications for the care and support available to midwives themselves currently. During emergencies and even outside of these, it was raised that many women are raped including the midwives, sometimes by the husbands of the

women they are caring for - hence the need to improve safe working conditions for midwives, as well as to ensure a comprehensive curriculum for midwifery education to cover all these areas.

One of the participants commented that having an enabling environment for a quality full scope midwifery education in a fragile or emergency setting is very difficult to achieve. It was suggested that it may not be possible to implement quality full scope midwifery education in these circumstances, but rather to identify the specific skills that can be planned and built on the ground in an emergency. There were further discussions on movement of people across many countries and the need for midwives to be able to relate with women and children who are asylum seekers or refugees, and to know how meet their needs.

## Closing words and next steps

### Closing words

While closing the meeting, Mary Renfrew thanked everyone for the progress that was made. She mentioned that there is great potential for this work to make a difference. For example, when considering the work of the middle-income-group, more than 60% of the world's population live in just four countries, India, Brazil, China and Nigeria, so to make a difference in absolute numbers we should be influencing what happens there.

Mary stated that what we have witnessed at the meeting was a co-constructed, co-created, piece of work and that the work is continuing. She mentioned that it will be important to keep this network that has been formed so that people can learn from each other and to use the joint energy to further input into the plans that the WHO is working on. She described briefly that there is going to be another consultation in Cairns, Australia as part of the WHO Collaborating Centres Conference, and that all the research questions identified from the group work will be fed to the Research Alliance of The Lancet Series on Midwifery.

Mary thanked the SKP, Green Templeton College and WHO for supporting this important piece of work. She thanked the planning group who had organised the meeting; all speakers who were themselves participants; all participants; and Hannah and Adetoro who facilitated the sessions and who have the responsibility of writing the report. Denise Lievesley thanked all participants and expressed her thanks to Lord Nigel Crisp who had also in turn sent in a thank you email to the group about how he enjoyed the networking and interaction the previous evening and how those were valuable to his work supporting nurses and midwives.

## Appendix 1

### Group 1: Fragile country

Fragile countries are often trapped in cycles of poverty, insecurity and weak governance. Low coverage of health services, and limited human resource base often result in a fragmented health system. Although maternal and newborn health services in the country are mainly provided by nurse/midwives, the length and quality of the midwifery education vary. Midwifery education is often still characterised by inadequate number of qualified faculty and lacking in practical application. Studies are also sometimes disrupted by the conflict engulfing the country. Fragile countries often don't have functioning government approved regulatory body for midwives or a system for licensing to practice.

### Group 2: High-income-country

Midwifery is often an autonomous profession and is regulated by a midwifery regulatory body which regulates the quality of midwifery education and practice. Midwifery education and training programmes take place in approved educational facilities. Students should usually finish courses in at least three years and can gain dual nurse midwifery qualification. HICs often have regulatory authorities which provides leadership in maintaining a strong regulatory framework by building the midwifery competencies, setting national standards for midwifery practice, administering the national midwifery registration examination and approving educational programmes. The body together with the relevant midwifery associations form a three-pillar approach to promote midwifery regulation, education and practice.

### Group 3: Middle-income-country

Many middle-income countries are characterised by over- medicalisation of childbirth as midwives are not seen as autonomous practitioners and many services are obstetric led. Midwifery education varies in length and quality and students often have several choices of midwifery education programme. Middle income countries may have a regulatory body and midwifery association, some districts in MICs may regulate midwifery and others do not.

### Scenario 4: Low -income-country

In many LICs the first point of contact for basic emergency obstetric care in a community setting is the health post and primary health care centre. These health facilities are staffed with nurses, thus the quality of care received is determined by the midwifery competency of nurses stationed in these peripheral health facilities. Midwifery education is combined with nursing education. Midwifery education is taught in numerous ways with different qualifications obtained. These countries often lack a government approved regulatory body for midwives, a protected title for midwives and a system for licensing to practice covering public and private sector. There is not always a professional body for midwives.

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